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Right to health and indigenous peoples with a focus on children and youth

Study by the Expert Mechanism on the Rights of Indigenous Peoples

Summary

In its resolution 30/4, the Human Rights Council requested the Expert Mechanism on the Rights of Indigenous Peoples to prepare a study on the right to health and indigenous peoples with a focus on children and youth and to present it to the Council at its thirty-third session.

The present study consists of a critical analysis of the content of the right to health vis-à-vis indigenous peoples and a review of the legal obligations of States and others in terms of fulfilling that right.

Expert Mechanism advice No. 9 on the right to health and indigenous peoples is contained in the annex.

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I. Introduction

1. In its resolution 30/4, the Human Rights Council requested the Expert Mechanism on the Rights of Indigenous Peoples to conduct a study on the right to health and indigenous peoples with a focus on children and youth and present it to the Council at its thirty-third session.

2. The Expert Mechanism called for States, indigenous peoples, national human rights institutions and other stakeholders to provide information for the study. The submissions received have been made available on the Expert Mechanism website whenever permission to do so has been granted. The study also benefited from presentations made at the Expert Seminar on Indigenous Peoples and the Right to Health (Montreal, Canada, 21-22 February 2016) organized by the Office of the United Nations High Commissioner for Human Rights and the Institute for the Study of International Development at McGill University. The Expert Mechanism would like to thank the University of Auckland Faculty of Law for providing research support. The Pan American Health Organization reviewed the study, provided comments and contributed to the text.

3. Although this is the first study of the Expert Mechanism focusing on the right to health, previous studies have addressed the links between access to justice and the health of indigenous women and indigenous persons with disabilities (A/HRC/27/65), the health implications for indigenous peoples of disaster risk reduction initiatives (A/HRC/27/66) and the importance of indigenous cultures and languages for the health of indigenous peoples (A/HRC/21/53).

4. Indigenous peoples' conceptualization of health and well-being is generally broader and more holistic than that of mainstream society, with health frequently viewed as both an individual and a collective right, strongly determined by community, land and the natural environment. The Permanent Forum on Indigenous Issues has noted that the right to health "materializes through the well-being of an individual as well as the social, emotional, spiritual and cultural well-being of the whole community" (see E/2013/43-E/C.19/2013/25, para. 4). Indigenous concepts of health often incorporate spiritual, emotional, cultural and social dimensions in addition to physical ones. Those concepts are inextricably linked with the realization of other rights, including the rights to self-determination, development, culture, land, language and the natural environment.

5. Indigenous peoples' concept of health is frequently disregarded within non-indigenous health systems, however, creating significant barriers to access (see A/HRC/30/41, para. 31). In particular, a lack of understanding of social and cultural factors deriving from the health-related knowledge, attitudes and practices of indigenous peoples can have deleterious effects on indigenous well-being. Indigenous peoples worldwide experience higher rates of health risks, poorer health and greater unmet needs in respect of health care than their non-indigenous counterparts. Forced assimilation, political and economic marginalization, discrimination and prejudice, poverty and other legacies of colonialism have also led to a lack of control over individual and collective health.

6. A comprehensive analysis of the state of indigenous peoples' health is beyond the scope of the present study, which contains, instead, a critical analysis of the content of the right to health vis-à-vis indigenous peoples and a review of the legal obligations of States and others in terms of fulfilling that right.

II. Right to health and indigenous peoples: legal and policy framework

A. Normative framework on the right to health

7. The right to health of all peoples has long been recognized, for example in the Universal Declaration of Human Rights, in particular its article 25, according to which everyone has the right to a standard of living adequate for the health and well-being of himself or herself and of his or her family, including food, clothing, housing and medical care and necessary social services.

8. The United Nations Declaration on the Rights of Indigenous Peoples recognizes the health rights of indigenous peoples and expands upon their varied dimensions and the interplay with rights such as the right to self-determination. Article 21 recognizes the right of indigenous peoples to the improvement of their economic and social conditions without discrimination. Article 23 recognizes their right to determine and to develop priorities and strategies for exercising the right to development and, in particular, to be actively involved in developing and determining health programmes affecting them and to administer such programmes through their own institutions where possible. Article 24 recognizes the right of indigenous peoples to their traditional medicines, to maintain their health practices and to access social and health services without discrimination; it affirms the equal right of indigenous individuals to the enjoyment of the highest attainable standard of physical and mental health. In addition, the Declaration recognizes the importance of upholding the collective rights of indigenous peoples. Finally, article 29 (2) requires States to take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior and informed consent.

9. Article 24 of the Declaration reflects the wording of article 12 of the International Covenant on Economic, Social and Cultural Rights, a binding treaty enshrining the right of all people to the highest attainable standard of mental and physical health. Article 12 sets out an inclusive right, incorporating both health care and the social determinants of health, and containing freedoms and entitlements: notably, the freedom to control one's own health and the entitlement to a system of health protection that provides equality of opportunity in realizing the highest attainable standard of health. Non-discrimination and equal treatment are among its key components; and, although many elements are subject to "progressive realization" in view of resource constraints, obligations such as non-discrimination are of immediate effect. While States have primary responsibility for realizing the right to health, that responsibility is shared by all in society and individuals should have the opportunity to participate in decision-making processes affecting the realization of their rights. States should respect, protect and fulfil the right to health and ensure that health-care facilities, goods and services are available, accessible, acceptable and of good quality (see E/CN.4/2003/58, para. 34).

10. In its general comment No. 14 (2000) on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights further expands upon the right to health vis-à-vis indigenous peoples, noting that they have the right to specific measures to improve access to health services and care, which should be culturally appropriate and take into account traditional practices and medicines, and that States should provide resources for indigenous peoples to design, deliver and control services. The Committee recognizes the collective dimension of health for indigenous peoples and acknowledges the deleterious effect on health of the displacement from traditional territories and environments that occurs as a consequence of development-related activities.

11. Article 25 of the International Labour Organization (ILO) Indigenous and Tribal Peoples Convention, 1989 (No. 169), requires States to ensure that adequate health services are made available to indigenous peoples and to provide resources to indigenous peoples to allow them to design and deliver such services under their own control. It also requires preference to be given to the training and employment of local community health workers. The provision recognizes the importance of primary care and community-based health services and of coordination with other social, economic and cultural measures. Implementation of article 25 is supported by non-discrimination provisions (art. 3) and provisions requiring States to consult with and ensure the effective participation of indigenous peoples with the objective of achieving consent in relation to proposed measures (art. 6).

12. Health-related rights are also recognized in other binding international instruments, including the Convention on the Rights of the Child (art. 24), the Convention on the Elimination of All Forms of Discrimination against Women (arts. 10-14), the Convention on the Rights of Persons with Disabilities (art. 25) and the International Convention on the Elimination of All Forms of Racial Discrimination (art. 5). Certain regional instruments also uphold the right to health, including the African Charter on Human and Peoples' Rights (art. 16), the African Charter on the Rights and Welfare of the Child (art. 14), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (art. 14) and the American Declaration on the Rights of Indigenous Peoples (art. XVII). The Pan American Health Organization too has passed a number of resolutions concerning the right to health of indigenous peoples.[1]

13. Treaty bodies and special procedures, including the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the Special Rapporteur on the rights of indigenous peoples, have examined the right to health from an indigenous perspective. Key findings of these mechanisms are referred to throughout the present report.

B. Other key instruments, policy processes and documents

14. In 2014, the States participating in the high-level plenary meeting of the General Assembly known as the World Conference on Indigenous Peoples committed themselves to ensuring that indigenous individuals have equal access to the highest attainable standard of physical and mental health and to intensifying efforts to reduce rates of HIV and AIDS, malaria, tuberculosis and non-communicable diseases and to ensure access to sexual and reproductive health. The importance of indigenous peoples' health practices and their traditional medicine and knowledge was also recognized.[2]

15. The Sustainable Development Goals, adopted in 2015, also touch on issues concerning indigenous well-being.[3] Goal 3 (to ensure healthy lives and promote well-being for all at all ages) directs States to work towards achieving universal health coverage, which will require States to extend services to indigenous peoples. The Goals on poverty, food security, equitable and quality education, and gender equality are also relevant to indigenous peoples' well-being. Goals 13 (on climate change), 14 (on the protection of ecosystems) and 15 (on sustainable development) are central to the realization of indigenous peoples' health rights, as they are closely interrelated with the rights to self-determination and to the use of traditional lands, territories and resources. Goal 16

[1] For example, see resolution CD47.R18.
[2] General Assembly resolution 69/2.
[3] General Assembly resolution 70/1.

(on access to justice and accountable and inclusive institutions) has clear implications for indigenous peoples' right to health, particularly in terms of redress. Finally, Goal 17 (which includes a target on the availability of disaggregated data) calls for enhanced capacity-building to increase data availability, which will assist States in identifying and remedying health inequities.

16. The negotiations held at the twenty-first session of the Conference of the Parties to the United Nations Framework Convention on Climate Change are also relevant, given the disproportionate impact that climate change has on indigenous peoples. Those negotiations culminated in the adoption of the Paris Agreement, in the preamble to which the parties to the Convention recognized the rights of indigenous peoples, referring specifically to the right to health. The parties also acknowledged that adaptation action should follow a country-driven, participatory and fully transparent approach, based on and guided by the knowledge of indigenous peoples, where appropriate (see decision 1/CP.21, annex). While the importance of the effective participation of indigenous peoples had already been noted (see decision 1/CP.16), the Paris Agreement went further by explicitly referring to human rights, signalling that States recognized the links between climate-related obligations, the right to health and indigenous peoples' rights.

17. Finally, the Guiding Principles on Business and Human Rights are also highly relevant to indigenous peoples, who disproportionately experience health rights infringements through development-related activities carried out by non-State actors. Although they are not parties to international human rights conventions, non-State actors nevertheless have a responsibility to respect human rights, and adherence to the Guiding Principles is necessary for indigenous peoples' health rights to be fully realized.

III. Treaty rights, self-determination and health

18. The right to health is an indispensable element of indigenous peoples' very existence and a central component of their right to self-determination. The right to self-determination is contained both in article 3 of the United Nations Declaration on the Rights of Indigenous Peoples and article 1 of the International Covenant on Economic, Social and Cultural Rights. All human rights are interdependent, including the rights to health and self-determination. Indeed, full realization of health-related rights cannot be achieved without self-determination, which is a non-derogable right the realization of which has associated benefits in respect of health and other social and cultural rights. These can include an improved diet, more frequent exercise and a renewed connection with traditional economic bases.[4]

19. Some treaties between indigenous peoples and States provide mechanisms for the realization of indigenous peoples' rights to health and self-determination. These legal agreements are thus highly relevant to a right-to-health analysis. Treaty No. 6, for example, to which the British Crown and indigenous peoples in Canada became parties starting in the 1870s, included a "medicine chest clause" and a "famine and pestilence clause" that have subsequently been interpreted as guarantees for the provision and delivery of health-care services, medicines and supplies to indigenous peoples by the Crown.[5] Treaties in other countries provide for self-determination, which implicitly includes control over decisions concerning the health and well-being of indigenous peoples, indirectly facilitating the realization of the right to health. In New Zealand, the right to health of the Maori people is effectively affirmed in the Treaty of Waitangi, which provides for the protection of self-

[4] Submission by the New Zealand Human Rights Commission.

[5] Submissions by the Maskwacis Cree and the Assembly of First Nations.

determination and cultural possessions (tangible and intangible), shared decision-making and equal participation in society without discrimination.

20. The Special Rapporteur on the right to health has stated that the right to health raises important issues of law, such as treaty rights to health.[6] Article 37 of the United Nations Declaration on the Rights of Indigenous Peoples confirms that indigenous peoples have the right to the recognition, observance and enforcement of treaties. In line with article 43, the survival, dignity and well-being of indigenous peoples are dependent on the rights recognized in the Declaration, including the right to health, the right to self-determination and treaty rights. Although the rights to self-determination and health are not contingent upon the recognition of treaties, their formal inclusion in treaties provides a mechanism for safeguarding those rights and strengthens the commitment of States to working with indigenous peoples as equal partners in improving their living conditions. Accordingly, States that have not yet adhered to such treaties should consider formally acknowledging those rights in agreements with indigenous peoples.

21. The principle of free, prior and informed consent is another integral element of the right to self-determination. It entitles indigenous peoples to effectively determine the outcome of decision-making affecting them. It is both a process and a substantive mechanism to ensure respect of indigenous peoples' rights. Free, prior and informed consent should be respected in decisions regarding health legislation, policy and programmes affecting indigenous peoples, which are frequently taken without any meaningful consultation. Health-care policymaking should adhere to both article 12 of the International Covenant on Economic, Social and Cultural Rights (on the right to participate in decision-making) and the United Nations Declaration on the Rights of Indigenous Peoples, and reflect the principles outlined by the Expert Mechanism in its study on the right to participate in decision-making (A/HRC/18/42).

IV. Indigenous peoples' right to health: State obligations

22. Indigenous peoples worldwide share many challenges in realizing the highest attainable standard of health. The challenges are examined in the present report using the availability, accessibility, acceptability and quality framework, with State obligations outlined using the respect, protect and fulfil framework. The availability, accessibility, acceptability and quality framework extends beyond the infrastructure for delivering health care to encompass the facilities, goods and services comprising the underlying determinants of health care, such as safe drinking water and adequate food and sanitation.[7]

A. Availability, accessibility, acceptability and quality framework

Availability

23. Public health and health-care facilities, goods and services should be available in sufficient quantity within a State, depending on its level of development. However, availability is often constrained for indigenous peoples and communities. For example, in certain areas in Africa where indigenous nomadic pastoralists and communities are located, health infrastructure is non-existent.[8] For facilities, goods and services to be available, they

[6] Statement to the Third Committee of the General Assembly, 29 October 2004.

[7] Committee on Economic, Social and Cultural Rights, general comment No. 14.

[8] United Nations, Department of Economic and Social Affairs, *State of the World's Indigenous Peoples: Indigenous Peoples' Access to Health Services*, second volume (New York, 2015).

must also be functional. Facilities located in areas inhabited by indigenous peoples are frequently not operational owing to a lack of staff, medicines, supplies and other consumables.

Accessibility

24. The four primary dimensions of accessibility are non-discrimination, physical accessibility, economic accessibility and information accessibility. For indigenous peoples, these four dimensions often intersect. Indigenous peoples are very likely to experience discrimination when accessing health-care facilities, goods and services. Doctors, nurses and other health-care professionals may refuse to treat indigenous peoples or indigenous peoples undergoing treatment may encounter discriminatory beliefs, practices and experiences, fuelling fear and distrust that further discourages use of health-care facilities. That situation is amplified for indigenous persons with disabilities. Racism may even lead to misdiagnosis and mistreatment for serious illnesses. Physical accessibility is an issue for indigenous peoples, many of whom live in geographically isolated areas, often because of displacement or the encroachment of non-indigenous peoples on their land.

25. Economic accessibility is another concern for indigenous peoples, who are frequently among the most socioeconomically marginalized groups in society. This is particularly true in countries without universal health care or with high out-of-pocket costs for consumers. Information accessibility is also constrained for indigenous peoples: this can be attributed to a number of factors, including health information being unavailable in indigenous languages; higher rates of illiteracy among indigenous peoples with limited educational opportunities; a lack of contact with health-care providers owing to unavailability; and discriminatory or paternalistic attitudes among health-care providers.

Acceptability

26. The Committee on Economic, Social and Cultural Rights has acknowledged that the right to take part in cultural life encompasses cultural appropriateness, which should be taken into account in providing health-care services.[9] Unfortunately, the health-care facilities, goods and services available to indigenous peoples are often unacceptable in nature. Interpersonal and structural racism frequently lead to system-wide policies and practices that marginalize or exclude individuals and minimize access to facilities, goods and services. One example of a basic failure to provide acceptable care is the non-provision of services in indigenous languages (see CEDAW/C/FIN/CO/7), which constitutes structural racism. Such failures can result in indigenous peoples internalizing stigma, creating additional barriers to health care. Moreover, indigenous people are frequently blamed for their illnesses and medical needs, either individually or as a group. Negative attitudes and a lack of cultural sensitivity among health-care providers in some jurisdictions also have an impact on indigenous peoples' ability to seek health care.

Quality

27. Health-care facilities, goods and services should be scientifically, medically and culturally appropriate, and of good quality. That requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe drinking water and adequate sanitation. Tension often exists between mainstream health-care services, which are generally evidence-based and perceived to be of high quality, and the traditional health-care practices of indigenous peoples, on which there is a paucity of evidence, often

[9] See the Committee's general comment No. 21 (2009) on the right of everyone to take part in cultural life.

owing to a lack of research. That should not be viewed exclusively as a source of tension between indigenous peoples and mainstream health-care providers. Indigenous communities themselves often face challenges internally in seeking to balance traditional and modern approaches to health and in addressing other social issues.[10]

B. Respect, protect and fulfil framework

Respect

28. Articles 2 (2) and 3 of the International Covenant on Economic, Social and Cultural Rights and article 24 of the United Nations Declaration on the Rights of Indigenous Peoples prohibit discrimination in access to health care and the underlying determinants of health. States must refrain from denying or limiting indigenous peoples' access to public health-care facilities, goods and services. That immediate obligation is not subject to the principle of progressive realization. States should also refrain from prohibiting or impeding indigenous peoples' use of traditional preventive care, healing practices and medicines.

29. Laws, policies and programmes concerning health should be reviewed (together with indigenous peoples) and discriminatory elements removed or replaced. That obligation extends to laws that are not de jure discriminatory but that have a disproportionate impact on indigenous peoples. The obligation to respect extends to abstaining from enforcing broader discriminatory laws or practices that can have detrimental health effects. For example, laws and policies sanctioning practices such as the forced sterilization of indigenous women and female genital mutilation should be removed.

30. The obligation to respect extends to the underlying determinants of health. States should refrain from unlawfully polluting the air, the water and the soil, for example through industrial waste from State-owned facilities or extractive industries. Such activities are too frequently carried out on land inhabited by indigenous peoples and, along with the agricultural use of pesticides, can represent a violation of indigenous peoples' health-related rights.[11]

31. Indigenous peoples must also be permitted to self-identify within States, which would facilitate the collection of data disaggregated by health and other criteria, for the provision of funding and assistance in realizing health-related rights. While certain jurisdictions have banned the collection of data disaggregated by ethnicity for compelling reasons, such laws should not be applied to prevent indigenous peoples from improving their well-being.[12]

Protect

32. States often turn a blind eye to racism in health-care settings, even in the presence of pervasive, persistent evidence that indigenous peoples are treated discriminatorily. States should take measures to ensure equal access to treatment and health-care facilities within their jurisdiction, as well as to protect indigenous peoples from discrimination perpetrated by third-party health-care providers. States should consider implementing workforce awareness-raising activities and campaigns challenging racist behaviour and stereotyping and promoting more culturally sensitive approaches.

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[10] Submission by the Inuit Circumpolar Council.

[11] See, e.g., *Social and Economic Rights Action Centre and Center for Economic and Social Rights v. Nigeria* (2001).

[12] Ian Anderson and others, "Indigenous and tribal peoples' health (The Lancet–Lowitja Institute Global Collaboration): a population study", *The Lancet*, vol. 388, No. 10040 (20 April 2016).

33. States should protect indigenous communities from actions by private companies and other third parties that deny indigenous peoples their sources of nutrition, medicinal plants and livelihoods through increased pressure on land, environmental degradation or displacement. Doing so necessarily includes respecting the principle of free, prior and informed consent. States should prevent the appropriation and commodification of indigenous knowledge, traditional medicines and practices by third parties. Article 31 of the United Nations Declaration on the Rights of Indigenous Peoples confirms that indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, medicines, knowledge of the properties of fauna and flora, and sports and traditional games. They also have the right to develop their intellectual property over such cultural heritage, traditional knowledge and traditional cultural expressions.

34. Although indigenous peoples have the right to engage in traditional health-care practices, States should take steps to work with indigenous communities towards the eradication of harmful practices such as female genital mutilation.[13] More research needs to be carried out into traditional medicines, procedures and other interventions. However, such research, and any potential commercialization, must take place in partnership with indigenous peoples.

35. States should consider the wishes of indigenous communities living in voluntary isolation or initial contact in recognition of their greater vulnerability and need of protection. States should develop preventive programmes to protect the health of those groups, in particular by protecting their lands and territories from environmental damage and by avoiding the transmission of diseases to which those groups lack immunity. States must also create plans to provide access to mainstream and traditional medicine where it is sought and develop an emergency plan to be implemented in the event of a threat of imminent widespread mortality.[14]

36. Finally, States should ensure that adequate mechanisms exist for the provision of redress and remedy in cases of infringements of the right to health, through mainstream or indigenous juridical systems (A/HRC/27/65), which may have certain advantages in respect of the resolution of complaints. In the Philippines, for example, complaints of violence against women heard through the traditional justice system have reportedly been resolved quickly, with high rates of acceptance by the parties.[15]

Fulfil

37. States should formulate and adopt national strategies to ensure that all individuals have access, without discrimination, to the health facilities, goods and services necessary to achieve the highest attainable standard of health. The creation of a national strategy should be accompanied by implementation plans and right-to-health indicators for effective monitoring, evaluation and accountability. States that are developing national action plans for the implementation of the United Nations Declaration on the Rights of Indigenous Peoples, as called for by the World Conference on Indigenous Peoples, should ensure that

[13] Committee on the Rights of the Child, general comment No. 11.

[14] OHCHR and the Spanish Agency for International Development Cooperation, "Directrices de proteccion para los pueblos indigenas en aislamiento y en contacto inicial de la región amazónica, el Gran Chaco y la Región Oriental de Paraguay" (Geneva, May 2012). Available from http://www.amazonia-andina.org/sites/default/files/directrices-de-proteccion-para-los-pueblos-indigenas-en-aislamiento-y-en-contacto-inicial_0.pdf.

[15] Submission by the Asia Indigenous Women's Network.

such plans include measures to fulfil indigenous peoples' right to health. As indigenous peoples have the right to specific measures to improve their access to health services and care, the immediate obligation to create a national health plan requires States to make provision for indigenous peoples' needs in a "mainstream" plan, as in Guatemala,[16] or a separate indigenous health plan, like the Maori Health Strategy, *He Korowai Oranga*, in New Zealand.[17] In addition, States should ratify and incorporate into national law relevant international instruments containing health rights, such as the Declaration, the ILO Indigenous and Tribal Peoples Convention, 1989 (No. 169), and the International Covenant on Economic, Social and Cultural Rights.

Facilitate

38. In accordance with the right to self-determination, States should provide sufficient resources to indigenous communities to create and operate their own health-care initiatives. Care provided by indigenous community-controlled organizations is often of a higher quality than that provided by mainstream services, significantly improving the availability and accessibility of health care. Indigenous organizations can create a virtuous cycle in respect of health and employment, serving as prominent employers of indigenous peoples and helping to combat poverty within indigenous communities. In Australia, the Aboriginal community-controlled health-care sector employs nearly 4,000 people and services over 60 per cent of Aboriginal people outside major metropolitan centres, with superior performance to mainstream services noted on key indicators.[18] In Colombia, 80 per cent of the professional staff of Pueblo Bello indigenous hospital in Valledupar are of indigenous origin — a significant achievement in intercultural practice.[19]

39. States should also facilitate access to health-care services through improved birth registration processes, where appropriate. Article 7 of the Convention on the Rights of the Child gives every child the right to be registered immediately after birth. Yet, many registration systems remain inadequate in relation to indigenous births. A lack of registration and identification documents directly impedes access to health-care facilities, goods and services where identification is a prerequisite for obtaining care (CRC/C/CRI/CO/4) and prevents the collection of disaggregated data, which is vital in monitoring disparities in health-care status between different ethnic groups. Registration can be facilitated through targeted registration campaigns, as in Brazil,[20] or use of indigenous registrars or a specific minorities registration section within State institutions, as in Panama, Peru and Thailand; alternatively, traditional birth attendants can improve birth registration rates, as has occurred in Ghana and Malaysia.[21] Birth registration should not, however, be a precondition for accessing health-care services.

[16] Submission by Guatemala.

[17] See www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga.

[18] Kathryn Panaretto and others, "Aboriginal community controlled health services: leading the way in primary care", *Medical Journal of Australia*, vol. 200, No. 11 (16 June 2014).

[19] Anna R. Coates and others, "Indigenous child health in Brazil: the evaluation of impacts as a human rights issue", *Health and Human Rights Journal*, vol. 18, No. 1 (16 May 2016).

[20] Ibid.

[21] United Nations Children's Fund, "Birth registration: right from the start", Innocenti Digest series No. 9 (March 2002).

Provide

40. Although certain indigenous peoples have stated that communities should take ownership over responses to emerging crises and rely less on external support,[22] this does not absolve States of their obligations to provide financial and other support. States incur a special obligation to provide (for those who do not have means) the necessary health insurance and health-care facilities, a specific right under the International Covenant on Economic, Social and Cultural Rights.[23] Even in times of severe resource constraints, individuals and groups in situations of vulnerability should be protected by the adoption of relatively low-cost, targeted programmes (E/1991/23-E/C.12/1990/8). States can adopt measures, temporarily or permanently, to remedy structural discrimination: these can include programmes or the provision of funding or other resources to achieve the highest attainable standard of health.

41. States should also provide certain resources while indigenous peoples establish their own services and workforce cadre. For example, in the absence of sufficient medical professionals able to speak indigenous languages, States should provide interpretation services facilitating effective communication in health-care settings, as is done in Norway, where a 24-hour-a-day Sami interpretation service has been established in collaboration with indigenous peoples.[24] Affordable versions of such programmes could be implemented by other States, given the rapidly increasing prevalence of mobile telephone coverage worldwide. Training and incorporating traditional indigenous practitioners into health-care systems could also address immediate shortages of medical staff in remote indigenous territories.

Promote

42. States should ensure that health-care research agendas sufficiently recognize and involve indigenous peoples. Failure to collect health data disaggregated by ethnicity, self-identified indigenous status or cultural identity can conceal deep inequities. Disaggregated data should be collected, in a consensual manner, to identify barriers to the enjoyment of the right to health and for inclusive policymaking. Such data should address issues such as gender, socioeconomic status and disability, as data focused purely on indigenous status does not fully capture the composite rights of indigenous peoples who are marginalized owing to other aspects of their identity.[25]

43. For health-care facilities, goods and services to be acceptable to indigenous peoples, they must be culturally appropriate. This requires communicating in a respectful and inclusive way, empowering patients in decision-making and building relationships so that patients and providers work together to ensure maximum effectiveness of care.[26] To achieve this, three steps are necessary: changes should be made to mainstream health-care facilities, goods and services; more indigenous individuals should be trained as health-care providers; and indigenous-specific services should be created.

44. To improve mainstream services, States should ensure that curricula of medical and health-care training programmes render graduating professionals culturally competent. Programmes should include education on colonial history and its legacies (where relevant), indigenous culture (including traditional approaches to medicine), stereotyping and racism,

[22] Submission by the Inuit Circumpolar Council.

[23] Committee on Economic, Social and Cultural Rights, general comment No. 14.

[24] Submission by Norway.

[25] Doreen Demas, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

[26] National Aboriginal Health Organization, *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators* (Ottawa, 2008).

and health-care disparities and social inequities. Information on effective communication with indigenous peoples should also be included. Specific programmes can also be created addressing indigenous health, such as the University of Northern British Columbia Aboriginal child and youth mental health certificate (for students who want to practice in remote indigenous communities) and the Native American Child Health initiative created by the American Academy of Pediatrics (dedicated to indigenous health care).

45. States should facilitate the entry of indigenous professionals in health care, as indigenous peoples are currently underrepresented. Facilitation of workforce entry can take many forms: for instance, through training quotas, earmarked funding or scholarships, and/or travel allowances. Indigenous peoples can receive professional training to bridge the divide between mainstream facilities, goods and services, and indigenous communities. Such training should be conducted sensitively and without prejudice to indigenous medicinal and health-related knowledge and practice.

46. States should also promote health through the provision of culturally appropriate information concerning healthy lifestyles and nutrition, disease and illnesses (including mental illness), harmful traditional practices, and the availability of services. Information should be provided in the patient's language and information mechanisms that incorporate non-verbal communication patterns, as well as cultural beliefs and practices, should be developed. In some indigenous communities, certain issues, such as HIV/AIDS and sexual and reproductive health, remain taboo: State cooperation with indigenous organizations is vital in implementing culturally appropriate awareness-raising campaigns among these communities.

47. The spiritual and biomedical benefits of traditional health-care practices and traditional medicines can promote and enhance indigenous health and bring unwell people into contact with health-care systems, facilitating access to care. Rather than stigmatizing and suppressing such practices and medicines, States should consider incorporating them into their health planning and promotion activities.

48. Indigenous peoples should be supported in making informed choices about their health by providing them with information and by taking State measures designed to facilitate healthy choices, including physical activity. States should promote healthy and traditional diets among indigenous people through the protection of indigenous peoples' traditional agricultural practices, education campaigns and, where necessary, direct provision of or economic subsidies for healthy foods, particularly in rural or remote areas where processed or packaged foods are frequently more easily available and affordable to indigenous peoples.

V. Indigenous children and youth and the right to health

49. Alongside the International Covenant on Economic, Social and Cultural Rights and the United Nations Declaration on the Rights of Indigenous Peoples, article 24 of the Convention on the Rights of the Child requires States to take appropriate measures to ensure the realization of the highest attainable standard of health for children. In its general comment No. 11 (2009) on indigenous children and their rights under the Convention, the Committee on the Rights of the Child noted that indigenous children frequently suffer poorer health than non-indigenous children owing to inferior or inaccessible health services, and that positive measures may be required to eliminate conditions causing discrimination and ensure the equal enjoyment of Convention rights. The Committee urged States to consider implementing special measures to ensure that indigenous children are not discriminated against and can maintain their cultural identity, and noted that States parties have a positive duty to ensure that indigenous children have equal access to health services

and to combat malnutrition as well as infant, child and maternal mortality. In its general comment No. 15 (2013) on the right of the child to the highest attainable standard of health, the Committee interpreted the right to health of all children as including the right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants of health.

50. Unfortunately, alarming gaps in child health indicators persist between indigenous and non-indigenous populations globally. Infant mortality rates remain significantly higher among indigenous groups than among their mainstream counterparts.[27] Indigenous women and children can be vulnerable to violence, malnutrition, malnourishment, anaemia and malaria.[28] Some of these discrepancies are attributable to inequalities in social determinants of health. Disproportionately large numbers of indigenous children live in poverty (general comment No. 11) and in remote areas with limited access to health care, quality education, justice and participation opportunities (see E/C.19/2005/2, annex III).

51. Indigenous peoples continue to experience intergenerational trauma owing to the removal of children from families and residential schooling. The health impacts of such practices are profound and include mental illness, physical and sexual abuse, self-harm and suicide, and drug or alcohol addiction. A correlation has been demonstrated between the intergenerational effects of those events and suicide[29] and sexual abuse during childhood.[30]

52. Indigenous children and youth are particularly vulnerable to human rights violations, because of their age and the intersectional nature of the discrimination experienced by indigenous peoples. Children and youth have not historically been recognized as holders of rights; that is especially the case for indigenous children, who are frequently deprived of fundamental rights concerning their families, communities and identity. The combined effect of intergenerational trauma and lack of progress towards the realization of indigenous human rights has resulted in many indigenous children experiencing a multitude of early and traumatic life experiences, placing them at risk of ill health, mental illness, suicide and contact with the criminal justice system.[31]

53. Indigenous youth frequently find themselves caught between their indigenous languages, customs and values and those of the wider community. They often migrate from their traditional communities to urban areas to seek out increased employment and educational opportunities, incurring increased health risks. Indigenous youth not only experience higher rates of unemployment than their non-indigenous counterparts; they are also vulnerable to depression, substance abuse and other risky health outcomes that occur in the absence of strong social support and in the presence of discrimination.

54. In addition to difficulties experienced by indigenous peoples in accessing appropriate and good-quality health services, indigenous children and youth face three key issues compounding their social and economic disadvantage, relating to education, family and community integrity, and mental health.

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[27] Ian Anderson and others (see footnote 12).

[28] Submission by the Indigenous Women's Network, India.

[29] Zahra Rehman, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

[30] Gregory Corosky, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

[31] Hannah McGlade, *Our Greatest Challenge: Aboriginal Children and Human Rights* (Canberra, Aboriginal Studies Press, 2013).

Education

55. Education is a key underlying determinant of health for indigenous peoples. Illiteracy rates are frequently high (CERD/C/EDU/CO/20-22) and indigenous children are significantly less likely than non-indigenous children to attend school, which undermines health through decreased health literacy and loss of the numerous, indirect benefits of higher educational attainment. Lower educational attainment is "inextricably tied" to homelessness and the overrepresentation of indigenous peoples in the prison system.[32] Decreased participation in formal education is frequently the result of a combination of a lack of availability, accessibility, acceptability and quality. Even where services are accessed, boys and girls record different completion rates: for instance, 89 per cent of indigenous girls in Peru aged 12-16 drop out of school (see A/HRC/29/40/Add.2, para. 68).

56. States should do more to provide redress for these health rights violations. Investing in indigenous children's early development through education and providing support to families (e.g. around parenting) are highly effective means of reducing health inequalities. States should cooperate to ensure the adoption of effective interventions: for instance, nurse-family partnerships have been adapted for use in indigenous communities following evidence of effectiveness in the United States of America.[33] At the primary and secondary levels, educational facilities should be made available and accessible by States, including through radio broadcasts and long-distance education programmes or through the establishment of mobile schools for nomadic indigenous peoples (general comment No. 11).

Family and community integrity

57. The importance of healthy communities and families to indigenous children cannot be underestimated. Such support networks provide physical, mental and social health benefits, help to break entrenched cycles of intergenerational disadvantage and build resilience and capability. The Committee on the Rights of the Child has noted, in its general comment No. 11, that maintaining the best interests of the child and the integrity of indigenous families should be primary considerations in the development of health and other programmes. Unfortunately, indigenous children are still removed from their homes at a significantly higher rate than their non-indigenous counterparts, which can cause significant childhood trauma. Moreover, indigenous children are vulnerable to abuse while in the care of the State. States should prevent and provide redress for any action that deprives indigenous peoples, including children, of their ethnic identities, such as placement of indigenous children in alternative care.

Mental health

58. The high prevalence of mental illness and suicide among indigenous peoples is alarming, particularly among indigenous youth. There are various protective factors and preventive strategies for suicide, including strong cultural affiliations (A/HRC/21/53). One systematic review found that school-based suicide prevention strategies reduced depression and feelings of hopelessness and that "gatekeeper" training (teaching specific community groups how to identify and support individuals at high risk of suicide) increased the

[32] Submission by Brenda Gunn, University of Manitoba, Canada

[33] Submission by Australia

knowledge and ability to assist those at risk of suicide. Other strategies effective in non-indigenous communities, such as sui[illegible]cide-risk screening, could also be considered.[34]

59. Information on best practices for the prevention of mental illness and suicide should be shared between communities. Research in the circumpolar region has demonstrated the value of community-based and culturally guided interventions and evaluations, which could be utilized elsewhere.[35] Regional coordinating projects, such as the Rising Sun project facilitated by the Arctic Council, assist in sharing data and comparing interventions.[36] Finally, promising new initiatives such as the "health scouts" programme in the Philippines, where children lead resilience training, should be explored.[37]

VI. Health rights of key indigenous groups

A. Women's health

60. Indigenous women experience a broad, multifaceted and complex spectrum of mutually reinforcing human rights abuses (A/HRC/30/41); these frequently include health rights violations that extend beyond denial of access to medical services.

61. Firstly, indigenous women face many barriers to the realization of their sexual and reproductive health and rights. A lack of available, accessible and acceptable health-care services, as well as limited access to good-quality care, contributes to disproportionately high rates of maternal mortality, teenage pregnancy and sexually transmitted infections and to low rates of utilization of contraceptives, as indigenous women are often excluded from reproductive health services. High rates of teenage pregnancy can also be attributed to certain structural causes such as a lack of education for girls and forced marriage.

62. Secondly, indigenous women persistently experience high rates of maternal ill-health. Globally, maternal mortality rates are consistently higher among indigenous women than among non-indigenous women.[38] Indigenous women are frequently at risk of undernourishment, anaemia and other nutritional deficiencies, illnesses such as gestational diabetes and frequently have little or no access to basic antenatal, intra-partum and postnatal care.[39]

63. Finally, indigenous women and girls continue to experience violence at higher rates than the general population. In accordance with article 22 (2) of the United Nations Declaration on the Rights of Indigenous Peoples, States should take measures to ensure that indigenous women enjoy full protection against all forms of violence and discrimination. Nevertheless, indigenous women are disproportionately represented among victims of rape, assault and other forms of violence. Many forms of violence against indigenous women have a strong intergenerational element and stem from marginalization and legacies of

[34] Anton Clifford, Christopher Doran and Komla Tsey, "A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand", *BMC Public Health*, vol. 13 (2013).

[35] Jennifer Redvers and others, "A scoping review of indigenous suicide prevention in circumpolar regions", *International Journal of Circumpolar Health*, vol. 74 (2015).

[36] Submission by the Inuit Circumpolar Council.

[37] Penelope Domogo, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

[38] Ibid.

[39] Michael Gracey and Malcolm King, "Indigenous health part 1: determinants and disease patterns", *The Lancet*, vol. 374, No. 9683 (July 2009).

colonization that permit or enable abuse.[40] The health-related impacts of violence against women include injuries, sexually transmitted infections, gynaecological problems, mental illness and substance dependence. Violence against women also affects children exposed to such violence, who experience higher rates of morbidity and mortality.[41]

64. These challenges can be overcome in partnership with indigenous peoples. For example, community maternity wards, maternal houses and waiting homes have reduced perinatal risk in Guatemala and Peru.[42] Involvement and further training of traditional midwives in modern health-care delivery approaches may reduce maternal morbidity and mortality, while also improving service acceptability. States should consider opportunities for South-South cooperation concerning sexual and reproductive health, in particular in relation to intercultural standards (E/2013/43-E/C.19/2013/25).

65. In many indigenous communities, birth rates remain significantly higher compared with the national average, partly reflecting the value indigenous communities place on motherhood and childbearing. These views can occasionally clash with prevailing beliefs in mainstream medicine regarding, for instance, birth practices and contraception. The perceived conflict between the rights of indigenous peoples and the rights of women, however, is often illusory. The elimination of customary law or practices that violate women's rights, such as forced marriage and domestic violence, has long been sought by many indigenous peoples. Other practices that are traditional or preferred by indigenous peoples should not be prohibited by States; instead, dialogue on pregnancy spacing, contraceptive use and parenting should be conducted in a culturally sensitive manner.

66. States must do more to address gender-based violence. Indigenous women and girls frequently have no effective legal remedies for such acts. In certain jurisdictions, violence perpetrated against women by State officials such as police officers and military or paramilitary forces occurs. In such cases, women experience a two-fold rights violation: firstly, through the experience of violence and, secondly, through the lack of redress from the very mechanism that has perpetrated the violence. States must take steps to prevent such violence and ensure that acceptable mechanisms to provide redress for such violations are available and accessible to all women.

B. Health of indigenous persons with disabilities

67. Indigenous persons experience higher rates of disability globally compared to the general population. Barriers such as multiple forms of discrimination, poverty, systemic and physical barriers and violence contribute to the lack of full enjoyment of their human rights. The Convention on the Rights of Persons with Disabilities recognizes the right to health (art. 25) and the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination, including indigenous persons with disabilities (preamble).

68. Indigenous children with disabilities face physical, systemic and attitudinal barriers that impede the realization of their rights to education, accessible services and disability-related rehabilitation programmes. Too often, indigenous children with disabilities face

[40] Ellen Gabriel, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

[41] World Health Organization, "Violence against women: intimate partner and sexual violence against women", factsheet No. 239 (January 2016). Available from www.who.int/mediacentre/factsheets/fs239/en/.

[42] United Nations Population Fund and the Spanish Agency for International Development Cooperation, "Promoting equality, recognizing diversity: case stories in intercultural sexual and reproductive health among indigenous peoples" (Panama, August, 2010).

discrimination, abuse and bullying from their peers, caregivers and members of their communities. Indigenous status, intellectual disability and imprisonment frequently co-occur.[43]

69. Indigenous persons with disabilities may also experience delays in recognition of their condition owing to racism or discrimination, or even an over-diagnosis of their intellectual disability owing to cultural bias in testing.[44] Moreover, "institutionalized ableism" can obscure undiagnosed illnesses among people living with disabilities, where medical abnormalities are attributed to disability rather than to a separate pathology.[45] The potential for this to occur in indigenous people is significant given frequent issues with language and other communication barriers and given health professionals' lack of education. Training and education curricula should include content regarding the needs of indigenous persons with disabilities, so as to raise the awareness of practitioners.

70. Indigenous persons living with a disability in remote areas are often required to periodically reconfirm their disability through central medical organizations to remain eligible for disability pensions, creating hardship. States and other actors should recognize and address the multiple burdens of discrimination suffered by indigenous persons with disabilities.

VII. Current challenges relating to indigenous peoples and the right to health

A. Communicable and non-communicable diseases

71. Indigenous peoples experience disproportionately high levels of infectious diseases such as HIV/AIDS, malaria and tuberculosis, with the risk of becoming infected with HIV increasing among those migrating to urban areas. States should recognize the higher risk profile of indigenous peoples in relation to these diseases and the multiple burden of discrimination indigenous peoples suffer upon contracting such illnesses. In addition, indigenous peoples disproportionately suffer from "neglected" tropical diseases such as trachoma, helminth infections, yaws, leprosy and strongyloidiasis.[46] Widespread or mass consensual treatment for these conditions should be considered by States, where effective medications exist. It is also important that State funding for indigenous health activities is not predicated on wellness, particularly in communities already experiencing disadvantage. In the Russian Federation, an increasing incidence of tuberculosis in indigenous communities has been used as a criterion for the non-approval of or reduction in federal subsidies.[47]

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[43] Matthew Frize, Dianna Kenny and C.J. Lennings, "The relationship between intellectual disability, indigenous status and risk of reoffending in juvenile offenders on community orders", *Journal of Intellectual Disability Research*, vol. 52, No. 6 (June 2008).

[44] Ibid.

[45] Submission by the First Peoples Disability Network.

[46] Peter Hotez, "Aboriginal populations and their neglected tropical diseases", *PLoS Neglected Tropical Diseases*, vol. 8, No. 1 (January 2014).

[47] Russian Federation, federal government act No. 217 of 10 March 2009 on approval of the terms of distribution of subsidies from the federal budget to the budgets of subjects of the Russian Federation to support the economic and social development of the indigenous peoples of the North, Siberia and the Far East of the Russian Federation.

72. There has also been an enormous rise in the incidence of non-communicable diseases among indigenous peoples, who experience disproportionately high rates of cardiovascular illness and diabetes. Such high rates are linked to the migration of indigenous peoples from rural to urban areas, whose lifestyles rapidly change to incorporate modern diets high in calories, fat and salt.[48] For example, in the Philippines, development and changes in agricultural practices and dietary preferences have contributed to soaring rates of diabetes, renal disease, cardiovascular disease, hypertension and cancer.[49] Moreover, global data reveal high rates of alcohol and tobacco use among indigenous peoples, in particular men.

73. States should take specific steps to combat the extraordinary burden of these illnesses among indigenous peoples. Affordable access to key medications, such as insulin and anti-hypertensives, should be ensured, as their high out-of-pocket costs can lead to a rapid, yet preventable, deterioration in health. Telemedicine or mobile health initiatives to monitor indigenous peoples with chronic illness living in remote areas should also be considered. The value of exercise and sport should not be underestimated, both in terms of non-communicable disease prevention and indirect health benefits, such as increased social inclusion and self-esteem. Among indigenous Australian youth there is a positive relationship between self-reported participation in sport and health outcomes, including mental health; involvement in sport has even been shown to deter juvenile delinquency.[50] It is very encouraging that traditional games and sports events such as the World Indigenous Games held in 2015 are being supported and promoted by States, given their role in prevention of illness and wellness promotion.

74. Good occupational health for indigenous persons is also crucial. For example, some indigenous peoples suffer from silicosis as a consequence of poor occupational hygiene in stone processing factories, a traditional livelihood in some indigenous territories of the Russian Federation. States should protect the health of indigenous peoples working in both traditional and mainstream industries.[51]

B. Environmental health, climate change and displacement

75. Poor environmental health has long been a concern of indigenous peoples. The Committee on the Rights of the Child has highlighted the importance of environmental health to children and recognized climate change as a particularly urgent threat to indigenous children's health and lifestyles, noting that States should put children's health concerns at the centre of their climate change adaptation and mitigation strategies (general comment No. 15). Those who are already vulnerable, including indigenous peoples, experience the worst effects of climate change (A/HRC/31/52). For example, climate change is contributing significantly to food insecurity among the Inuit peoples of the Canadian Arctic, whose hunting and fishing practices have been threatened by significant reductions in their icy hunting grounds.[52] Replacement of traditional food sources with mainstream dietary elements is costly in such locations, and carries its own health risks.

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[48] Michael Gracey and Malcolm King (see footnote 39).

[49] Penelope Domogo, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

[50] Submission by Cultural Survival.

[51] Outcome document of the expert seminar entitled "Finno-Ugric peoples and sustainable development: health of indigenous peoples", held in Petrozavodsk, Russian Federation, on 25 and 26 May 2016.

[52] Sheila Watt-Cloutier, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

76. The development-related activities of States or third parties, such as multinational corporations, may also compromise indigenous peoples' underlying determinants of health, such as food, safe drinking water and sanitation. This can occur through the displacement of indigenous peoples from traditional lands or from land or water contamination, which in turn results in infringements of the right to health and other rights, including the right to life.[53] Contamination can also occur through the use of pesticides that are banned in certain States but that are nevertheless exported and used elsewhere.[54] It is an ironic outcome of development and globalization that indigenous peoples are consistently among those most vulnerable to food insecurity, malnutrition and chronic diseases, given their wealth of traditional knowledge regarding sustainable, healthy living in rural ecosystems. This vulnerability is a living reality for many indigenous peoples: diabetes and cardiovascular diseases have been causally linked to the impact of colonization and dispossession of lands, territories and resources.[55]

77. Efforts should be made to promote cooperation between indigenous peoples and businesses and to minimize the negative impact of development, as examples from the Russian Federation illustrate.[56] Identifying indigenous peoples' rights to land, forests and marine and other natural resources is also vital to indigenous peoples' livelihoods and well-being. The importance of maintaining a connection with the land is also recognized in regional legal instruments.[57] Where indigenous peoples are empowered to care for and maintain their land, another virtuous cycle is created: natural resources are used more sustainably, employment prospects are created and the overall health of communities improves. Indigenous peoples should retain decision-making control over these resources to ensure sufficient food and nutritional security, especially where communities are dependent on marine and terrestrial resources for survival (E/2005/43-E/C.19/2005/9).

[53] See e.g. *Xákmok Kásek Indigenous Community v. Paraguay*, Inter-American Court of Human Rights, 24 August 2010.

[54] Submission of the International Indian Treaty Council.

[55] Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples: Volume 3 — Gathering Strength* (Ottawa, Canada Communication Group, 1996).

[56] United Nations Development Programme, Russian Union of Industrialists and Entrepreneurs and Global Compact Network Russia "United Nations Global Compact Network Russia: corporate social responsibility practices".

[57] See the African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa, art. 4 (5).

Annex

Expert Mechanism advice No. 9 on the right to health and indigenous peoples

A. General advice

1. The right to health of indigenous peoples is enshrined in multiple international and national instruments, and forms an important part of human rights law. That right is interrelated with various key rights accrued by indigenous peoples, including the rights to self-determination; development; culture; land, territories and resources; language; and the natural environment.

2. Indigenous concepts of health are broad and holistic, incorporating spiritual, environmental, cultural and social dimensions in addition to physical health. Forced cultural assimilation; land dispossessions and the use of indigenous land for the extractive industry; political and economic marginalization; poverty; and other legacies of colonialism have led to a lack of control over individual and collective health and undermined the realization of indigenous peoples' health rights.

3. Health statistics the world over illustrate indigenous peoples' disadvantaged position in terms of access to quality health care and their vulnerability to numerous health problems, including communicable and non-communicable diseases. Indigenous women, youth, children and persons with disabilities face particular challenges, including higher maternal mortality and suicide rates, and face multifaceted forms of discrimination.

B. Advice for States

4. States should recognize and enhance the protection of the right to health of indigenous peoples by ratifying and incorporating into their domestic law the Indigenous and Tribal Peoples Convention, 1989 (No. 169), of the International Labour Organization, the International Covenant on Economic, Social and Cultural Rights and other key human rights treaties, and by taking concrete measures to implement the United Nations Declaration on the Rights of Indigenous Peoples.

5. States should recognize the inherent right of indigenous peoples to determine their own futures, including in terms of exercising control over their own health. States should consider entering into treaties with indigenous peoples, explicitly safeguarding rights to self-determination and health, and implement relevant treaty commitments where they already exist.

6. Health is an indispensable component of indigenous peoples' very existence, survival and entitlement to live in dignity and determine their own futures. States should therefore seek the free, prior and informed consent of indigenous peoples before implementing laws, policies or programmes affecting their health or health rights.

7. States should implement national plans for indigenous peoples' health with the full participation of indigenous peoples and with their free, prior and informed consent, or create or amend existing national health plans to incorporate specific programmes and policies for indigenous peoples. States should also incorporate the right to health into national action plans for the implementation of the United Nations Declaration on the Rights of Indigenous Peoples.

8. States should ensure that indigenous peoples are given full access to publicly run health-care facilities, goods and services, as well as to facilities, goods and services relating to underlying determinants of health, such as safe and potable water and adequate food and sanitation. The introduction and implementation of comprehensive anti-discrimination laws and the collection and use of disaggregated data are vital for achieving this objective.

9. Laws and policies that permit or sanction violence against indigenous peoples, even if only implicitly, should be repealed by States, and steps should be taken to address violence perpetrated by State representatives (such as armed forces) and third parties. Violence in health-care settings, such as forced sterilization and female genital mutilation, as well as discrimination against lesbian, gay, bisexual and transgender indigenous persons, should be explicitly prohibited.

10. States should not endanger the environmental health of indigenous peoples, including through air pollution or water and soil contamination by State-owned facilities or other activities. States should take steps to protect indigenous peoples from environmental damage caused by third parties (such as private companies) by minimizing, through legislative and practical measures, the impact that extractive industries in particular have on the physical and mental health of indigenous peoples.

11. Indigenous peoples should be permitted to identify as distinct groups within States and States should take positive measures to ensure the collection of disaggregated data on indigenous peoples. States should facilitate access to health-care services through improved birth registration processes and by removing birth registration as a precondition for accessing health-care services.

12. States should take steps to support the preservation of indigenous cultures and protect indigenous peoples from the appropriation and commodification of their knowledge, their traditional medicines and other traditional practices by third parties. Indigenous peoples should be allowed to practice traditional medicine and enjoy its benefits but harmful practices that infringe on other rights, such as female genital mutilation, should be eradicated, in partnership with indigenous peoples.

13. States should provide sufficient resources to indigenous peoples to facilitate the creation and operation of their own health-care initiatives or, in the absence of indigenous-controlled services, provide programmes and interventions directly to indigenous peoples, including through the implementation of special measures necessary for indigenous peoples to fully realize their health rights.

14. States should secure access to quality health-care services, including preventive care, for nomadic and remote indigenous peoples, indigenous peoples in conflict-affected areas and indigenous persons in detention, including through mobile clinics, telemedicine and information and communications technologies.

15. States should ensure that interpretation services are available to indigenous patients, to ensure adequate communication in health-care settings. Recognizing the role of languages in the healing process, States should also promote the use of indigenous languages in health-care settings.

16. States should take steps to train indigenous health-care workers and accredit indigenous health practitioners and integrate them into health-care systems. States should also improve health-care training curricula to train health-care workers to deliver culturally appropriate services, and create programmes and services to raise the awareness of practitioners regarding the treatment and management of indigenous persons.

17. Culturally appropriate health promotion tools and information should be devised and disseminated by indigenous peoples in partnership with States, to prevent both communicable and non-communicable diseases. Sufficient resources should be allocated

for healthy lifestyle information programmes to be devised and States should design specific strategies for the prevention of communicable and non-communicable diseases in partnership with indigenous peoples and with their free, prior and informed consent.

18. States should implement legislation, policies and programmes that support indigenous peoples in making informed choices about their health and that include initiatives to improve indigenous peoples' choices regarding the underlying determinants of health, such as healthful food and physical activity.

19. Educational initiatives for indigenous peoples should be prioritized by States, given the strong direct and indirect links between health and educational attainment. States should ensure that every indigenous child has access to primary and secondary education and that all indigenous peoples can access health-related educational resources.

20. The high rate of removal of indigenous children from their families and communities worldwide and the far-reaching health effects of intergenerational trauma attributable to such removal and placement in residential schools and other facilities should be further investigated by States. Steps should be taken to preserve the integrity of indigenous families in accordance with the rights of the child and to ensure that affected indigenous persons receive the preventive and curative health-care services they require for addressing sequelae such as mental illness.

21. States, in cooperation with indigenous peoples, must take immediate steps to reduce the high rate of indigenous suicide worldwide, in particular among children and youth. Proven preventive measures should be implemented in high-risk communities and sufficient resources should be allotted to achieve genuine improvements in mental health among indigenous peoples.

22. States should provide resources and materials to deliver culturally appropriate health care to women, especially in respect of maternal health and sexual and reproductive health and rights.

23. States should ensure that women are protected from violence by enforcing criminal laws and making use of indigenous juridical mechanisms. States should also offer support services and resources for women who experience violence, including monetary resources where necessary.

24. States should take steps to combat discrimination against indigenous persons with disabilities by implementing legislation, policies and programmes and creating mechanisms to protect these people from having their rights abused by third parties. States should also implement culturally appropriate services (diagnostic and otherwise), taking into account indigenous needs in identifying and managing disability.

25. States should promote the exercise of indigenous traditional games and sport, for example through the World Indigenous Games.

26. States need to legally recognize and protect the right of indigenous peoples to their lands, territories and resources through appropriate laws and policies, given their intrinsic connection with the rights to health and to food.

27. States should make concrete plans to implement the provisions of the Paris Agreement, to mitigate the harmful effects of climate change and to tailor their health-sector planning to prepare for the health-related impacts of climate change, which disproportionately affect indigenous peoples.

28. States should ensure that adequate mechanisms are in place to provide redress and remedy for health rights infringements, including treaty rights, either through mainstream or indigenous juridical systems. Indigenous juridical systems may have certain advantages in terms of the resolution of complaints linked to health rights violations.

C. Advice for indigenous peoples

29. Indigenous peoples should strengthen advocacy efforts for the recognition of indigenous health rights and rights to self-determination, with the aim of creating equitably funded indigenous community-controlled health-care facilities, goods and services that are available, accessible, acceptable and of good quality.

30. Indigenous peoples should continue to advocate for proportionate representation and genuine participation in policy decisions regarding health care and push States to ensure that their free, prior and informed consent is obtained before implementing laws, policies and projects affecting indigenous peoples.

31. Indigenous peoples can take measures to protect and promote traditional medicine and associated practices, including advocating for State recognition to receive full protection under the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity, and for traditional healing and medical practices to be included in mainstream health-care services.

32. Indigenous peoples should ensure that steps are taken within communities to protect children and youth from practices with negative health impacts, including alcohol and drug misuse, and work with States to address these issues.

D. Advice for international organizations

33. While acknowledging the work done in this area by the Pan American Health Organization, the Expert Mechanism suggests that the World Health Organization consider appointing a global focal point on indigenous peoples' health issues to better address the pressing concerns that are raised worldwide in respect of the realization of indigenous health rights.

34. The United Nations, its agencies and other international organizations should emphasize the importance of providing mental health services to indigenous peoples and take steps to address suicide among indigenous people, in particular indigenous children and youth. The World Health Organization should also coordinate further research into youth suicide. The above-mentioned organizations should share information and support indigenous communities in tackling this issue.

35. The United Nations Population Fund should take into consideration the rights of indigenous peoples, in particular women and young people, in their planning, given the disproportionate burden of morbidity and mortality suffered by indigenous women and the gaps in the realization of their sexual and reproductive health rights.

36. The World Health Organization, the World Bank and other international organizations should conduct research into and disseminate information on best practices regarding community-controlled health care, to promote its adoption.

37. Together with States, multilateral agencies and other entities should also invest more resources in research and development for novel, affordable treatments for neglected tropical diseases that are disproportionately experienced by indigenous peoples.

38. The World Health Organization and other United Nations agencies should work with indigenous peoples to develop policy guidelines for incorporation of indigenous traditional knowledge into national health-care systems, including through the recognition of best practices.